Asthma Action Plan

PATIENT'S NAME: _____

HEALTH PLAN NAME: _____

DOCTOR'S NAME: _____

DOCTOR'S PHONE: _____

MY PERSONAL BEST PEAK FLOW READING: _____

EMERGENCY 911 OR _____

PARENT/GUARDIAN: _____

PHONE/PAGER NUMBER(S): _____

ADDRESS: _____

_____

PARENT #2/RELATIVE: _____

PHONE/PAGER NUMBER(S): _____

GREEN = GO

- ❑ BREATHING IS GOOD
- ❑ NO COUGH OR WHEEZE
- ❑ CAN WORK/PLAY

OR

- ❑ PEAK FLOW NUMBER ABOVE _____

(GREATER THAN 80% OF BEST)

NOTES _____

_____

_____

USE THESE DAILY CONTROLLER MEDICINE(S)

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

BEFORE SPORTS OR PLAY, USE THIS MEDICINE:

_____

YELLOW = CAUTION

- ❑ COUGH
- ❑ WHEEZE
- ❑ TIGHT CHEST
- ❑ WAKE UP AT NIGHT
- ❑ FIRST SIGN OF COLD

OR

- ❑ PEAK FLOW NUMBER _____ TO _____

CALL DOCTOR

- ❑ YES
- ❑ NO

TAKE THESE MEDICINES TO KEEP FROM GETTING WORSE

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

SPECIAL INSTRUCTIONS:

_____

RED = STOP

- ❑ MEDICINE IS NOT HELPING
- ❑ HEART RATE OR PULSE IS VERY FAST
- ❑ NOSE OPEN WIDE WHEN BREATHING
- ❑ HARD TO WALK OR TALK IN SENTENCES
- ❑ RIBS OR NECK MUSCLES SHOW WHEN BREATHING
- ❑ LIPS OR FINGERNAILS TURN GRAY OR BLUE

OR PEAK FLOW NUMBERS BELOW _____

GET HELP FROM A DOCTOR NOW!

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

SPECIAL INSTRUCTIONS:

_____

PHYSICIAN SIGNATURE (REQUIRED) _____

DATE: _____ PRINT NAME: _____